



THE UNIVERSITY *of* EDINBURGH

Edinburgh Research Explorer

Recent Evidence for CT with Older People

Citation for published version:

Laidlaw, K 2011, *Recent Evidence for CT with Older People*..

<<http://www.beckinstitute.org/SiteData/docs/CTTodyWint/567c9fddf2c9d83e/CTTody%20Winter%202011.pdf>>

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Publisher Rights Statement:

© Laidlaw, K. Recent Evidence for CT with Older People

General rights

Copyright for the publications made accessible via the Edinburgh Research Explorer is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

The University of Edinburgh has made every reasonable effort to ensure that Edinburgh Research Explorer content complies with UK legislation. If you believe that the public display of this file breaches copyright please contact openaccess@ed.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.



Cognitive Therapy Today

SPECIAL STUDENT SCHOLARSHIPS

See article below...



Dr. Aaron T. Beck and Dr. Judith S. Beck greeted participants at the Student Workshop in August 2010.

INSIDE THIS ISSUE...



FROM THE PRESIDENT EMERITUS
Conceptualization of Emotion
Aaron T. Beck, M.D.

1



FROM THE PRESIDENT
Student and Faculty Scholarships
Judith S. Beck, Ph.D.

1



GUEST AUTHOR
Cognitive Therapy with Older People
Ken Laidlaw, Ph.D.

4

FROM THE PRESIDENT

*Student and Faculty Scholarships:
Second Annual Competition*

Judith S. Beck, Ph.D.



FROM THE PRESIDENT EMERITUS

Conceptualization of Emotion

Aaron T. Beck, M.D.

Can you please help us spread the word?

We are pleased to be able to offer full tuition scholarships to our second annual student and faculty three-day cognitive behavior therapy workshop, to be held August 15-17, 2011, here in Philadelphia, but scholarship awardees may be able to attend a Level I workshop at another date (see beckinstitute.org).

Continued on Page 3

The listserv of the Academy of Cognitive Therapy had a very interesting and important discussion recently on the difference between the clinical and scientific model. Here is my latest thinking: The clinical model is based on observable and introspective phenomena and it is adequate in terms of the administration of cognitive therapy. Specifically, the clinical model consists of **situation/stimulus** ->

Continued on Page 2

Continued from Page 1

meaning (belief) -> emotion/behavior. The meaning, of course, can be ascertained by the automatic thought, image, or reflections. The scientific/theoretical model goes like this: **schema activation -> cognitive processing -> emotion.** The cognitive processing operates at several levels, or perhaps on a continuum, from unconscious to conscious. Some recent research on depression¹ has shown the following: 1) Based on neural scans, depressed patients show insensitivity to masked positive stimuli and hypersensitivity to masked negative stimuli. This is represented by activation of the amygdala without conscious awareness. Biasing is reversed after antidepressant medication (the patients showed an increased sensitivity to a previously attenuated response to positive stimuli after the administration of antidepressant medication). Non-depressed subjects show only the enhanced positive bias. This enhancement of positive reactivity after medication preceded any emotional or behavior change.²

2) Another group³ showed an inability of depressed individuals to maintain activation of the reward

system to positive stimuli. Putting it all together, the physiological findings parallel the psychological findings (i.e. the clinical model) and especially the observation that cognitive change precedes emotional change. I had previously described this theoretically in terms of activation of the depressive mode. Therapeutic application: One colleague has argued that since the processing is unconscious, a behavioral intervention would be the most effective approach. However, I believe that even though processing starts at a preconscious or unconscious level, it rapidly proceeds into conscious awareness. Specifically, the preconscious processing labels a particular event as good or bad, and focuses attention on the supposedly "bad" aspect of a particular stimulus (in depression). However, the complex conscious processing elaborates on this and will produce a thought such as "Since she did not respond to me with a smile, it means she doesn't like me and therefore nobody likes me." A cognitive intervention would then reframe this interpretation, and feeds back to reverse the negatively biased processing. It has been shown that this reframing involves an activation of a neural pathway from the cortical to the subcortical region (amygdala). The bottom-up automatic dysfunctional



"Even though processing starts at a preconscious or unconscious level, it rapidly proceeds into conscious awareness."

processing is modified by the top-down reflective processing. Cognitive therapy can be effective even when cognitive processing is largely unconscious.

References

1. Victor, T.A., Furey, M.L., Fromm, S.J., Ohman, A., & Drevets, W.C. (2010). Relationship Between Amygdala Responses to Masked Faces and Mood State and Treatment in Major Depressive Disorder. *Arch Gen Psychiatry*. 67(11): 1128-1138.
2. Harmer, C. J., O'Sullivan, U., Favaron, E., Massey-Chase, R., Ayres, R., Reinecke, A., Goodwin, G. M., & Cowen, P. J. (2009). Effect of Acute Antidepressant Administration on Negative Affective Bias in Depressed Patients. *Am J Psychiatry* 166: 1178-1184
3. Heller, A.S., Johnstone, T., Shackman, A.J., Light, S.N., Peterson, M.J., Kolden, G.G., Kalin, N.H., and Davidson, R.J. (2009) Reduced capacity to sustain positive emotion in major depression reflects diminished maintenance of fronto-striatal brain activation *Proceedings of the National Academy of the Sciences of the USA*. 106(52): 22445-22450

SPECIAL STUDENT SCHOLARSHIPS



Drs. Beck answered a variety of questions from participants at the Student Workshop in August 2010.

Continued from Page 1

The workshop will focus on the fundamentals of cognitive therapy and will include a conversation period with Dr. Aaron Beck, who will be celebrating his 90th birthday. The competition is open to graduate students, post-doctoral fellows, residents, and faculty in any mental health field, who study in any country.

Please answer the following questions, with no more than 200-500 words, *in the body* of an email and send it to beckinstitute@beckinstitute.org.

We regret that we will not be able to open attachments.

1. What is your exposure to

and experience in CBT?

2. How do you intend to use CBT in the future?
3. What involvement, if any, have you had in CBT-related research?

The deadline for applications is **March 1, 2011**. Scholarship winners will be notified by email during the first week of April. Applicants from 2010 can re-apply.

Finally, we would appreciate your telling friends and colleagues about the scholarship competition. We look forward to reading the applications for 2011. Good luck!

CBT WORKSHOP: LEVEL I

April 4 - 6, 2011

May 23 - 25, 2011

July 25 - 27, 2011

October 31 - November 2, 2011

December 12 -14, 2011

CBT WORKSHOP: LEVEL I Specialty Workshops

August 15 - 17, 2011
Student and Post-Doctoral Fellow

September 19 - 21, 2011
CBT for Soldiers

October 17 - 19, 2011
CBT for Children & Adolescents

CBT WORKSHOP: LEVEL II

May 2 - 4, 2011

June 20 - 22, 2011

November 14 - 16, 2011

BECK INSTITUTE
BOOKSTORE



Beck Institute's new conference room was finished over the summer. The facility is more spacious and has state of the art equipment to enhance onsite workshops conducted by our training staff.

Cognitive Therapy with Older People: A short review of treatment evidence and developments in theory.

Part One - Recent Evidence for CT with Older People

Ken Laidlaw, Ph.D.

Cognitive Therapy (CT) has always been a flexible treatment for the emotional disorders and it has been applied successfully in many settings with many treatment groups. This is as true for older people, as randomized controlled trials of CT largely generated in North America in the 1980s and 1990s testify. CT is now the most systematically evaluated of all the psychotherapies offered to older people. In 2009, Cuijpers and colleague's¹ meta-analysis demonstrated CT to be as efficacious with older people as with working age adults.

Two recently published RCTs in the UK demonstrate that CT works well with older people in primary care settings. Laidlaw and colleagues², where all participants met DSM-IV criteria for major depressive disorder criteria, is a very small study, but is one of very few psychotherapy studies in late life to show that CT alone is as efficacious as Treatment as Usual (TAU). In most cases, antidepressant medication managed by primary care physicians constituted TAU. At the end of treatment and at the six month follow-up, the CT alone group showed significant reductions in the Beck Hopelessness Scale in comparison to those who had continued to receive TAU. This demonstrates

that CT provides clients with active coping strategies with a consequent impact on sense of optimism and pessimism.

Serfaty and colleagues³ examined CT *plus* treatment as usual (usually CT plus medication) in comparison to Treatment as Usual (TAU) alone (usually antidepressant medication), but in addition added a third treatment option by including a talking treatment condition (TC). TC appears to function as an attention control treatment, where therapists are warm and interested in clients but are essentially passive, offering no help with problems. One would expect CT to outperform this passive talking treatment, and it does. Indeed, CT participants on average achieved better treatment outcomes compared to TC and TAU. This is important because, as Serfaty and colleagues assert, their results show depressed older people are not simply lonely or in need of a listening ear because CT outperformed TC. It would appear that the active nature of CT treatment impacts positively upon treatment outcome. As most cognitive therapists avow and Sefaty's study confirms, CT is more than a talking therapy and more accurately is a 'doing' therapy.

Treatment data for CT with older people is very good news and

Continued on Page 5

Join us on...



Be sure to tell your colleagues to subscribe to our newsletter—

Ask them to email us beckinstitute@beckinstitute.org

Continued from Page 4

serves to emphasize what most clinical geropsychologists know already; that older people are good candidates for psychotherapy and CT in particular is especially effective with older people with emotional problems. In many respects we should not be surprised that CT works well with older people, as older people tend to value the core principles of this treatment approach because it is skills enhancing, present-oriented, problem-focused and straightforward to use, as well as effective. It also aims to be

empowering of individuals, seeking to promote and encourage self-agency in the face of challenges, and adopts a non-pathologising stance in understanding a client's problems.

References

1. Cuijpers, P., van Straten, A., Smit, F., & Andersson, G. (2009). Is psychotherapy for depression equally effective in younger and in older adults? A meta-regression analysis. *International Psychogeriatrics*, 21, 16-24.
2. Laidlaw, K, Davidson, K.M., Toner, H.L., Jackson, G., et al. (2008). A randomised controlled trial of cognitive behaviour therapy versus treatment as usual in the treatment of mild to moderate late life depression. *International Journal of Geriatric Psychiatry*, 23, 843-850.
3. Serfaty, M., Haworth, D., Blanchard, M., Buszewicz, M., Murad, S & King, M. (2009) Clinical effectiveness of individual cognitive behavioural therapy for depressed older people in primary care. *Arch. Gen. Psychiatry*, 66, 1332-1340.



Dr. Aaron Beck uses the newly finished library to conduct live patient sessions, observed by participants in CBT Workshops at Beck Institute.

Beck Institute sends speakers around the U.S. and the world to present half-day to full-week workshops for hospitals, professional associations, national/international conferences, managed care companies, primary care physician groups, and other related organizations. Lecturers and keynote speakers offer a wide range of cognitive therapy topics to meet the needs of your setting.

SPEAKING ENGAGEMENTS

- **February 21-25, 2011 – Stanton, MI**
Speaker: Leslie Sokol, Ph.D.
Cognitive Behavioral Therapy Training with a Special Emphasis on Trauma
Montcalm Center for Behavioral Health
- **March 4, 2011 – Vancouver, BC**
Speaker: Judith S. Beck, Ph.D.
Cognitive Therapy for Personality Disorders
British Columbia Psychological Association
- **March 8, 2011 – New York, New York**
Speaker: Judith S. Beck, Ph.D.
Cognitive Therapy for Personality Disorders
nyc-cbt.org
- **March 25, 2011 – New Orleans, LA**
Speaker: Judith S. Beck, Ph.D.
Advances in Cognitive Therapy
American Counseling Association
- **June 2-5, 2011 – Istanbul, Turkey** Speaker: Judith S. Beck, Ph.D.
A CBT Program for Weight Loss and Maintenance; CBT for Personality Disorders
International Association for Cognitive Psychotherapy
- **June 27-30, 2011 – Copenhagen, Denmark**
Speaker: Donna Sudak, M.D.
Differential Diagnoses
- **July 14-16, 2011 – Seoul, Korea**
Speaker: Judith S. Beck, Ph.D.
Beck Diet Solution
Asian Cognitive Behavioral Therapy Conference
- **November 4-5, 2011 – Mérida, Spain**
Speaker: Leslie Sokol, Ph.D.
CBT for Difficult Cases